Member Consent for Release of Protected Health Information

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Use this form to allow Blue Cross* to share your protected health information (also known as PHI) with an individual or organization.

A Member who is giving consent

This form can only be used for one member. Please submit a separate form for each member.

Name _____ **Date of birth** _____

Enrollee ID (number on ID card beginning with 1 to 3 letters) _____

Address _____ **Daytime phone** _____

City _____ **State** _____ **ZIP** _____

B Protected health information to be shared *(check one)*

- [■] Any and all information (including personal, health, demographic, claims, billing and medical records) except Super PHI. Use the boxes listed below to include Super PHI.
- [ ] Only limited information (such as for specific treatments, dates of service or billing details)

(please describe) _____

Please check below if you would also like to include any of the following highly protected information (known as Super PHI):

- [ ] Substance abuse records (including alcoholism)
- [ ] AIDS or HIV treatment records
- [ ] Mental health services (does not include psychotherapy notes)
- [ ] Family Planning
- [ ] Psychotherapy notes (excluded from mental health)

C Person or organization that may receive your information

Note: If information is shared with a person or organization that is not legally required to obey privacy laws, the information may be shared with others and no longer protected.

Print first and last name for a person, and the most detailed name possible for an organization (for example, hospital name and department).

Recipient's full name Legal-Ease Digital Imaging LLC - 2496 Meadowcroft Dr Burton, MI 48519

Please check the box below describing the person or organization's relationship to you.

- [ ] Family member
- [ ] Friend
- [ ] Doctor or health care provider
- [■] Other *(describe)* Record Retrieval Company

Form continues on page 2.

* "Blue Cross," "we" or "us" refers to Blue Cross Blue Shield of Michigan, Blue Care Network, Blue Care Network Service Company, Blue Care of Michigan, Inc. or Blue Cross Complete of Michigan.

D Expiration and cancellation

This permission will expire *(check one box only)*:

☐ On this date (month, day and year, MM/DD/YYYY) _____

☐ When canceled, or upon my death

I understand that I can cancel this authorization at any time by submitting a written request on a standard form, available online at **bcbsm.com** or by calling the number listed on the back of my ID card. I understand that cancellation will not apply to information that has been released by this authorization.

E Authorization and signature

I allow the use and disclosure of my protected health information as described above. This information is being released at my request. I understand that my treatment, payment, enrollment or eligibility for benefits does not depend on whether I sign this authorization.

Signature of member

SIGN HERE _____ Date _____

IMPORTANT: Please read the form over carefully and be sure you have included all necessary information. We cannot take additional information by phone, fax or email. If information is missing we will have to contact you and request a new form.

Mail completed consent form to:

Blue Cross Blue Shield of Michigan Mail Code X425
600 East Lafayette Blvd.,
Detroit, MI 48226

or fax to: **1-866-894-3101.**

For additional assistance completing this form, call the number listed on the back of the member's ID card.

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Request For Access To Designated Protected Health Information Records

Use this form to request to inspect or obtain copies of your protected health information in the designated record set that we or our business associates, maintain.

Please provide the following information:

Name			Daytime phone number
Address			
City	State	ZIP code	Enrollee ID

You have the right to inspect or obtain a copy of protected health information in your designated record (except certain limited information, including: copies of psychotherapy notes, information we have compiled in anticipation of, or for use in a, civil, criminal or administrative action or proceeding, and certain other records). Elements in the designated record may include: eligibility, enrollment, payment, claims, appeals and case or medical management records. Unless you indicate otherwise, we will provide a summary of the records.

1. I am requesting:

   ☐ A summary of all records maintained in the designated record set:

   From: _____ (Month) _____ (Year)

   To: _____ (Month) _____ (Year)

   ☑ Specific records:

   Insurance Records, Claims, Billings, Claims Paid, Reports, Accident Reports, Medical Records and any other records.

2. Does this request include information about services received at a Blue Care Network Health Center? ☐ Yes ☐ No

3. The manner in which you prefer to access your records:

   ☐ Paper copies mailed to:

   _____
   Name of recipient

   _____
   Street address

   _____
   City, state, ZIP code

   ☐ In person. I would like to review the records in person at a location designated by Blue Cross Blue Shield of Michigan or Blue Care Network.

(Please complete the form on the opposite side)

☑ Electronically. Please select the format to receive your copies:

☐ PDF

☐ Other (please specify): _____

I would like my electronic copies delivered to:

☑ An email address: Pat Clifford - Legal-Ease Digital Imaging, LLC
Name of recipient

pat.legalease@gmail.com
Email address of recipient

☐ A postal address: _____
Name of recipient

_____
Street address

_____
City, state and ZIP code

Please send the copies on a: ☐ CD-ROM

☐ USB storage device

☐ Other (please specify) _____

4. Please sign and date:

_____ _____
Signature *Date*

If you are not the member, please sign and write today's date below, then check the box that describes your relationship to the member. If you are not the parent of a minor member, please attach proof of your relationship to the member. An authorization is required if you are not the personal representative.

Name of personal representative: _____

Signature of personal representative and date: _____

☐ Parent of minor child ☐ Legal guardian ☐ Power of attorney ☐ Executor ☐ Other

Please include the fax number as shown below.
Please mail completed form (and all documentation if needed) to: **Customer Individual Rights Unit**
BCBSM
600 East Lafayette, MC 1620
Detroit, MI 48226-2998

or Fax to: **1-877-522-4767**

Blue Cross Blue Shield of Michigan will make reasonable attempts to produce the designated record in the form and format you have requested. However, in the event that we cannot produce the records in the form and format you have requested, we have the right to contact you to establish a mutually agreeable alternative. We reserve the right to charge a reasonable fee to produce the copies in the form and format you have requested.

We speak your language

If you, or someone you're helping, needs assistance, you have the right to get help and information in your language at no cost. To talk to an interpreter, call the Customer Service number on the back of your card.

Si usted, o alguien a quien usted está ayudando, necesita asistencia, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al número telefónico de Servicio al cliente, que aparece en la parte trasera de su tarjeta.

إذا كنت أنت أو شخص آخر تساعده بحاجة لمساعدة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك دون أية تكلفة. للتحدث إلى مترجم اتصل برقم خدمة العملاء الموجود على ظهر بطاقتك

如果您，或是您正在協助的對象，需要協助，您有權利免費以您的母語得到幫助和訊息。要洽詢一位翻譯員，請撥在您的卡背面的客戶服務電話。

[illegible]

Nếu quý vị, hay người mà quý vị đang giúp đỡ, cần trợ giúp, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi số Dịch vụ Khách hàng ở mặt sau thẻ của quý vị.

Nëse ju, ose dikush që po ndihmoni, ka nevojë për asistencë, keni të drejtë të merrni ndihmë dhe informacion falas në gjuhën tuaj. Për të folur me një përkthyes, telefononi numrin e Shërbimit të Klientit në anën e pasme të kartës tuaj.

만약 귀하 또는 귀하가 돕고 있는 사람이 지원이 필요하다면, 귀하는 도움과 정보를 귀하의 언어로 비용 부담 없이 얻을 수 있는 권리가 있습니다. 통역사와 대화하려면 귀하의 카드 뒷면에 있는 고객 서비스 번호로 전화하십시오.

যদি আপনার, বা আপনি সাহায্য করছেন এমন কারো, সাহায্য প্রয়োজন হয়, তাহলে আপনার ভাষায় বিনামূল্যে সাহায্য ও তথ্য পাওয়ার অধিকার আপনার রয়েছে। কোনো একজন দোভাষীর সাথে কথা বলতে, আপনার কার্ডের পেছনে দেওয়া গ্রাহক সহায়তা নম্বরে কল করুন।

Jeśli Ty lub osoba, której pomagasz, potrzebujecie pomocy, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer działu obsługi klienta, wskazanym na odwrocie Twojej karty.

Falls Sie oder jemand, dem Sie helfen, Unterstützung benötigt, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer des Kundendienstes auf der Rückseite Ihrer Karte an.

Se tu o qualcuno che stai aiutando avete bisogno di assistenza, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, rivolgiti al Servizio Assistenza al numero indicato sul retro della tua scheda.

ご本人様、またはお客様の身の回りの方で支援を必要とされる方でご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合はお持ちのカードの裏面に記載されたカスタマーサービスの電話番号までお電話ください。

Если вам или лицу, которому вы помогаете, нужна помощь, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону отдела обслуживания клиентов, указанному на обратной стороне вашей карты.

Ukoliko Vama ili nekome kome Vi pomažete treba pomoć, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, pozovite broj korisničke službe sa zadnje strane kartice.

Kung ikaw, o ang iyong tinutulungan, ay nangangailangan ng tulong, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa numero ng Customer Service sa likod ng iyong tarheta.

Important disclosure

Blue Cross Blue Shield of Michigan and Blue Care Network comply with Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross Blue Shield of Michigan and Blue Care Network provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information in other formats. If you need these services, call the Customer Service number on the back of your card. If you believe that Blue Cross Blue Shield of Michigan or Blue Care Network has failed to provide services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person, by mail, fax, or email with: Office of Civil Rights Coordinator, 600 E. Lafayette Blvd., MC 1302, Detroit, MI 48226, phone: 888-605-6461, TTY: 711, fax: 866-559-0578, email: CivilRights@bcbsm.com. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health & Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail, phone, or email at: U.S. Department of Health & Human Services, 200 Independence Ave, S.W., Washington, D.C. 20201, phone: 800-368-1019, TTD: 800-537-7697, email: OCRComplaint@hhs.gov. Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Request for Release of Member's Protected Health Information

Blue Cross Blue Shield Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Use this form if you are a Blue Cross* member's personal representative and you need access to the member's protected health information (also known as PHI).

A Representative who is requesting information

Please print your name below and check the box that describes your relationship to the member.

Your full name _____

Relationship to member *(check one)*

- ☐ Legal guardian: *Attach guardianship documentation, which must have a court's stamp and signature.*
- ☐ Power of attorney: *Attach power of attorney (**must include** authorization of the release of healthcare information).*
- ☐ Executor: *Attach letter of appointment of executorship, which must have a court's stamp and signature.*
- ☐ Patient Advocate: *Attach Designation of Patient Advocate form, signed by member.*
- ☐ Other: *Please explain your relationship to the member and attach any supporting documentation.*

B Member whose information will be shared

This form can only be used for one member. Please submit a separate form for each member.

Name _____ **Date of birth** _____

Enrollee ID (number on ID card beginning with 1 to 3 letters) _____

Address _____ **Daytime phone** _____

City _____ **State** _____ **ZIP** _____

C Protected health information to be shared *(check one)*

- ☑ Any and all information (including personal, health, demographic, claims, billing and medical records)
- ☐ Only limited information (such as for specific treatments, dates of service or billing details)

*(please describe)*_____

Please check below if you would also like to include any of the following highly protected information (known as Super PHI):

- ☐ Substance abuse records (including alcoholism)
- ☐ AIDS or HIV treatment records
- ☐ Mental health services (does not include psychotherapy notes)

Form continues on page 2.

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D Expiration and cancellation

This permission will expire *(check one box only)*:

☐ On this date (month, day and year, MM/DD/YYYY) _____

☐ When canceled, or upon my death

I understand that I can cancel this authorization at any time by submitting a written request on a standard form, available online at **bcbsm.com** or by calling the number on the back of the member's ID card. I understand that cancellation will not apply to information that has been released by this authorization.

E Authorization and signature

I allow the use and disclosure of protected health information as described above. This information is being released at my request. I understand that treatment, payment, enrollment or eligibility for benefits does not depend on whether I sign this authorization. **Note: If information is shared with a person or organization that is not legally required to obey privacy laws, the information may be shared with others and no longer protected.**

Signature of personal representative

SIGN HERE _____ Date _____

ATTACH You must attach proof of your relationship to the member (See section A of this form for examples of acceptable documentation).

IMPORTANT: Please read the form over carefully and be sure you have included all necessary information and documentation. We cannot take additional information by phone, fax or email. If information is missing we will have to contact you and request a new form.

Mail completed consent form and documentation to:
Blue Cross Blue Shield of Michigan
Mail Code X425
600 East Lafayette Blvd., Detroit, MI 48226
or fax to: **1-866-894-3101.**

For additional assistance completing this form, call the number listed on the back of the member's ID card.

Medicare Plus Blue, BCN Advantage and Prescription Blue are PPO, HMO, HMO-POS and PDP plans with Medicare contracts. Enrollment in Medicare Plus Blue, BCN Advantage and Prescription Blue depends on contract renewal.